January 31, 2003

Ms. Gwendolyn L. Harris
Commissioner
New Jersey Department of Human Services
P.O. Box 700
Trenton, NJ 08625-0700

Dear Ms. Harris:

We are pleased to inform you that your application, entitled "New Jersey Standardized Parent Service Package," as modified by the Special Terms and Conditions (STCs) accompanying this award letter, has been approved as an amendment to project No. 21-W-00003/2-01 for title XXI, and to project No. 11-W-00164/2 for title XIX. New Jersey's request is being approved under the Administration's Health Insurance Flexibility and Accountability (HIFA) demonstration initiative.

Under HIFA, the Administration puts a particular emphasis on broad statewide coverage approaches like New Jersey's that target Medicaid and State Children's Health Insurance Program (SCHIP) resources to populations with income below 200 percent of the Federal poverty level (FPL) seeking to maximize private health insurance coverage options. Approval is under the authority of section 1115 of the Social Security Act (the Act) and covers the 5-year period of the original New Jersey SCHIP section 1115 demonstration through January 17, 2006.

The State of New Jersey submitted a HIFA proposal expanding coverage to approximately 12,000 uninsured custodial parents and caretaker relatives of children eligible for title XIX or title XXI who are not Medicaid eligible, and have family incomes up to and including 133 percent of the FPL. This expansion of coverage will be funded through title XXI with cost savings generated by standardizing the service package for both demonstration groups of parents in its current SCHIP section 1115 demonstration. In the HIFA demonstration, parents with income at or below 133 percent of the FPL will receive the most widely used HMO package with the largest commercial non-Medicaid enrollment, marketed in New Jersey, as is currently the case with parents with incomes up to and including 200 percent of the FPL. Parent coverage will be funded with title XIX funds in the event that the title XXI allotment is insufficient to fund such coverage, after first covering children.

Enclosed are the STCs that define the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acceptance of the award, including the STCs, within 30 days of the date of this letter.

Under section 1115(a)(1) of the Act, the following waivers and matching authority are approved for the term of the project:

Title XIX

Amount, Duration, & Scope Section 1902(a)(10)(B)

To enable the State to modify the Medicaid benefit package to provide a more limited package to the beneficiaries described below as demonstration population 1.

Cost Not Otherwise Matchable

Demonstration Population 1: Under the authority of section 1115(a)(2) of the Act, the following expenditures that would not otherwise be regarded as expenditures under title XXI will be regarded as expenditures under the State's title XXI plan:

Expenditures to provide coverage that meets the requirements of section 2103 of the Act and is equal to the most widely used HMO package with the largest commercial non-Medicaid enrollment, marketed in New Jersey, to individuals who are uninsured parents and caretaker relatives of Medicaid and SCHIP children with incomes between the previous Medicaid standard and 133 percent of the Federal poverty level (FPL).

SCHIP Requirements Not Applicable to Demonstration Population 1

1. General Requirements, Eligibility and Outreach Section 2102

The state child health plan does not have to reflect the demonstration population, and eligibility standards do not have to be limited by the general principles in section 2102(b). To the extent other requirements in section 2102 duplicate Medicaid or other SCHIP requirements for this or other populations, they do not apply, except that the State must perform eligibility screening to ensure that the demonstration population does not include individuals otherwise eligible for Medicaid under the standards in effect on August 31, 2000.

2. Restrictions on Coverage and Eligibility to Targeted Low Income Children Sections 2103 and 2110

Coverage and eligibility for this demonstration population are not restricted to targeted low-income children.

3. Federal Matching Payment and Family Coverage Limits Section 2105

Federal matching payment is available in excess of the 10 percent cap for expenditures related to the demonstration population and limits on family coverage are not applicable. Federal matching payments remain limited by the allotment determined under section 2104. Expenditures other than for coverage of the demonstration populations remain limited in accordance with section 2105(c)(2).

4. Annual Reporting Requirements Section 2108

Annual reporting requirements do not apply to the demonstration population.

Demonstration Populations 2 and 3: Under the authority of section 1115(a)(2) of the Act, the following expenditures that would not otherwise be regarded as expenditures under title XXI will be regarded as expenditures under the state's title XXI plan:

Demonstration Population 2. Expenditures to provide coverage consistent with section 2103 of the Act for uninsured custodial parents and caretakers of children eligible under the title XXI State plan, when the parents and caretakers have family incomes from 133 percent up to 200 percent of the FPL and are not eligible for Medicaid.

Demonstration Population 3. Expenditures to provide coverage consistent with section 2103 of the Act for uninsured pregnant women with family incomes between 185 and 200 percent of the FPL, who are not eligible for Medicaid.

SCHIP Requirements Not Applicable to Demonstration Populations 2 and 3:

1. General Requirements and Eligibility Standards Section 2102

The State child health plan does not have to reflect the demonstration population, and eligibility standards do not have to be limited by the general principles in section 2102(b). The State must perform eligibility screening to ensure that applicants for the demonstration population who are eligible for Medicaid are enrolled in that program and not in the demonstration population.

2. Restrictions on Coverage, and Eligibility to Children Section 2103 and 2110

Coverage and eligibility for this demonstration population is not restricted to children.

3. Federal Matching Payment and Family Coverage Limits Section 2105

Federal matching payment is available in excess of the 10 percent cap for expenditures related to the demonstration population and limits on family coverage are not applicable. Federal matching payments remain limited by the allotment determined under section 2104. Expenditures other than on the demonstration population, remains limited in accordance with section 2105(c).

4. Annual Reporting Requirements Section 2108

Annual reporting requirements do not apply to the demonstration population.

All requirements of the Medicaid and SCHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter, shall apply to the New Jersey demonstration project.

Your Project Officer for this demonstration is Ms. Jennifer Babcock, who may be reached at (410) 786-7219, and by email: jbabcock@cms.hhs.gov. Communications regarding program and administrative matters should be sent to the project officer at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
Family and Children's Health Programs Group
Division of State Children's Health Insurance
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Official communications regarding program matters should be sent simultaneously to the project officer and to Ms. Sue Kelly, Associate Regional Administrator for the Division of Medicaid and State Operations in the New York City regional office. Her address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and State Operations
26 Federal Plaza, Room 3811
New York, New York 10278-0063

Congratulations on the approval of your innovative approach to expanding health care coverage to the uninsured. We look forward to working with you on its implementation.

Sincerely,

/s/
Thomas A. Scully

Enclosure

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)
AMENDED

NUMBER:	**21-W-00003/2-01 (Title XXI – SCHIP funding)** **19-W-00164/2 (Title XIX – Medicaid funding)**
TITLE:	**New Jersey State Children's Health Insurance Program (SCHIP) Section 1115 Demonstration** ***Standardized Parent Service Package***
AWARDEE:	New Jersey Department of Human Services

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I. PREFACE

The following are Special Terms and Conditions for the award of the New Jersey State Children's Health Insurance Program Section 1115 Demonstration (New Jersey Demonstration) request submitted on September 26, 2000, and HIFA amendment request submitted July 30, 2002. Demonstration Populations 1, 2 and 3 are defined in the award letter that accompanies these Special Terms and Conditions. The HIFA amendment adds section 1115 authority to waive comparability of benefits package.

The Special Terms and Conditions have been arranged into two broad subject areas: General Conditions for Approval, and Program Design/Operational Plan. In addition, specific requirements are attached and entitled: General Financial Requirements Under title XXI (Attachment A), General Financial Requirements Under title XIX (Attachment B), Monitoring Budget Neutrality (Attachment C), and Operational Protocol (Attachment D).

The State agrees that it will comply with all applicable Federal statutes relating to Nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the Centers for Medicare & Medicaid Services (CMS) Central Office Project Officer and the Regional Office State Representative at the addresses shown on the award letter.

II. GENERAL PROGRAM CONDITIONS

A. The State shall prepare appropriate changes to the demonstration operational protocol document that incorporates the approved services package amendment. The operational protocol document continues to provide a single source for the policy and operating procedures applicable to this demonstration that have been agreed to by the State and CMS during the course of the waiver negotiation and approval process. The Special Terms and Conditions and Attachments include requirements, which should be included in the protocol. Attachment C is an outline of areas that should be included in the protocol.

B. The State will submit a phase-out plan of the demonstration to CMS 6 months prior to initiating normal phase-out activities and, if desired by the State, an extension plan on a timely basis to prevent disenrollment of enrollees if the waiver is extended by CMS. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS review and approval.

C. CMS may suspend or terminate any project, in whole or in part, at any time before the date of expiration whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights to challenge CMS' finding that the State materially failed to comply. CMS reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable for only normal close out costs.

D. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the waiver is withdrawn, CMS will be liable for only normal close out costs.

E. All requirements of the Medicaid and SCHIP programs expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are part, shall apply to the New Jersey Demonstration.

F. The State shall, within the time frame specified in law, come into compliance with any relevant changes in Federal law or regulations affecting the SCHIP program that occur after the demonstration award date. The State may submit to CMS a request for an amendment to the demonstration to request exemption from changes in law occurring after the demonstration award date.

G. Demonstration populations 2 and 3 will be subject to the same rules, policies, and procedures as the population under the title XXI State plan unless otherwise specified in this award

letter. In addition, demonstration populations 2 and 3 will be subject to the rules, policies, and procedures specified in the section 1115 demonstration proposal.

H. Demonstration population 1 will now receive the New Jersey Standardized Parent Service Package (NJ Family Care Plan D), which is consistent with the most widely used HMO package having the largest commercial non-Medicaid enrollment that is marketed in New Jersey. Demonstration population 1 will receive this benefits package after CMS approval of the HIFA proposal. Demonstration populations 2 continue to be covered by this benefits package. Demonstration population 3 will continue to receive the Medicaid benefits package.

I. Public Notice and Consultation. The State will continue to comply as demonstrated by previous documentation with the public notice requirements issued via September 27, 1994 edition of the Federal Register.

J. Cooperation with Federal Evaluators. The State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration program.

III. PROGRAM DESIGN/OPERATIONAL PLAN

A. Concurrent Operation

The State's title XIX State plan, as approved, and its title XXI State plan, as approved, will continue to operate concurrently with this section 1115 demonstration.

B. Maintenance of Coverage and Enrollment Standards for Children

1. The State shall not close enrollment, institute waiting lists, or decrease eligibility standards with respect to the children covered under its title XXI State plan while the demonstration is in effect. If the State closes enrollment, institutes waiting lists, or decreases eligibility standards with respect to SCHIP children, then the demonstration is terminated.

2. The State shall, throughout the course of the demonstration, continue to show that it has implemented procedures to enroll and retain eligible children for Medicaid and SCHIP. The State also shall throughout the course of the demonstration continue to show that it adopted and effectively implemented at least three of the following policies and procedures in its child health programs:

   - Use of a joint, mail-in application and common application procedures
   - Procedures that simplify the redetermination/coverage renewal process by allowing families to establish their child's continuing eligibility by mail and, in the State's separate SCHIP programs, by establishing effective procedures that allow children to be transferred between Medicaid and the separate program
   - Elimination of assets test
   - Twelve-month continuous eligibility
   - Presumptive eligibility

   The State may at any time submit to CMS a request for approval to change the particular policies or procedures used to meet this requirement.

3. The State will continue the monitoring process to ensure that expenditures for the HIFA amendment do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriate state match. The State will use title XXI funds to cover services for the SCHIP and HIFA populations in the following priority order:

   1) Children eligible under the title XXI state plan.
   2) Demonstration populations 1, 2 and 3.

The State may also, for the Demonstration populations 2 and 3:

- Lower the Federal poverty level (FPL) used to determine eligibility. For the Demonstration populations 2 and 3 the FPL cannot be lowered below 133 percent, and/or
- Suspend eligibility determination and/or intake into the program, or
- Discontinue coverage.

Before taking any of the above actions related to the priority system, New Jersey will provide 60-day notice to CMS.

C. BENEFITS

1. CMS is approving the New Jersey Standardized Parent Service Package (NJ Family Care Plan D) outlined in Attachment C of the HIFA demonstration proposal, which will be incorporated by the State in the Operation Protocol (Attachment D of these Special Terms and Conditions). If changes are made in the benefit package, the State must submit the proposed change to the operational protocol document, which must be reviewed and approved before any modifications can be implemented.

D. Enrollment Data Requirements

The State will provide CMS with copies of the following enrollment reports quarterly:

- Actual and unduplicated enrollment of the demonstration population, by income, gender, race, and ethnicity. This enrollment information shall be provided to CMS in hard-copy until such time as it can be reported through the SCHIP Statistical Enrollment Data System (SEDS).
- Number of children whose eligibility for SCHIP or Medicaid was up for redetermination and number of adults whose eligibility for the demonstration was up for redetermination.
- Number of children who were redetermined to be eligible for SCHIP or Medicaid and number of adults who were redetermined to be eligible for the demonstration.
- Number of children who applied for SCHIP or Medicaid and number of adults who applied for the demonstration but were denied for, at a minimum, the following reasons: income; failure to complete the application process; enrollment in other government programs; coverage by private insurance; or residence in another State.
- Number of children who were disenrolled from SCHIP or Medicaid and number of adults who were disenrolled from the demonstration for, at a minimum, the following reasons: increase or decrease in income; failure to complete the renewal process; failure to pay premiums; enrollment in other government programs; purchase of private coverage; or residence in another State.

E. General Reporting Requirements

1. Through at least the first 6 months after implementation, CMS and the State will hold monthly calls to discuss progress.

2. The State will submit quarterly progress reports, which are due 60 days after the end of each quarter. The reports should include, as appropriate, a discussion of events relating to the demonstration populations that occurred during the quarter that affect the following: health care delivery; the enrollment process for newly eligible adults and pregnant women; enrollment and outreach activities; access; complaints and appeals to the State; the benefit package; and other operational and policy issues. The report should also include proposals for addressing any problems identified in the report. The State will also include a separate section to report on progress toward agreed upon goals for reducing the rate of uninsurance and reducing the number of uninsured.

3. The State will submit a draft annual report no later than January 1 following the end of each Federal fiscal year. The annual report should include documentation of accomplishments; project status, including a budget update; quantitative and case study findings; policy and administrative difficulties; and progress on conducting the demonstration evaluation, including results of data collection and analysis of data to test the research hypotheses. Within 30 days of receipt of comments from CMS, a final annual report will be submitted.

4. At the end of the demonstration, a draft final report should be submitted to CMS for comments. CMS' comments must be taken into consideration by the State for incorporation into the final report. The CMS' document *Author's Guidelines: Grants and Contracts Final Reports* is available to the State upon request. The final report is due no later than 90 days after the termination of the project.

F. MONITORING

1. The State must monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make changes to its premium assistance program in response to substantial decreases in contribution levels or data showing significant substitution of coverage.

2. The State must monitor the impact of the demonstration on the group market with respect to health insurance issuer's participation requirements for employers.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

1. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved SCHIP plan and those provided through the New Jersey Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal Financial Participation (FFP) only for allowable New Jersey Demonstration expenditures that do not exceed the State's available title XXI funding.

2. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in Section 2115 of the State Medicaid Manual. Title XXI demonstration expenditures will be reported on separate Form CMS-21 Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services rendered or for which capitation payments were made). A separate Form CMS-21 Waiver and/or CMP-21P must be completed for Demonstration Population 1, for Demonstration Population 2 and for Demonstration Population 3.

    a. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

    b. The standard SCHIP funding process will be used during the demonstration. New Jersey must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. As a footnote to the CMS 21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

    c. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

3. New Jersey will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the waiver period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI child health program or demonstration until the next allotment becomes available.

4. Total Federal title XXI funds for the State's SCHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.

5. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.

6. If the State exhausts the available title XXI Federal funds for the claiming period, the State will continue to provide coverage to the approved title XXI State plan separate child health program population and the demonstration populations 2 and 3 with State funds (up to the limit of State's appropriation) until further title XXI Federal funds become available. Title XIX Federal matching funds will be provided for Demonstration population 1 if the title XXI allotment is exhausted, after a budget neutrality agreement is reached.

7. If title XXI allocations are expended and New Jersey must draw down regular title XIX matching funds for Demonstration Population 1 under section 1115 waiver authority, a Section 1115 budget neutrality agreement, including per-member per-month costs and trend rate, has been established for this Demonstration Population in consultation with New Jersey. CMS considered New Jersey's title XXI expenditure experience in establishing the cap. In order to provide for a seamless continuation of 1115 waiver authority for this population under title XIX, New Jersey should provide CMS with adequate notification if the State's projections indicate that it may exceed its title XXI allocation.

8. All Federal rules shall continue to apply during the period of the demonstration that title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to Demonstrations Populations 2 and 3. Before closing enrollment or instituting a waiting list, the State will provide 60-day notice to CMS.

ATTACHMENT B

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits that are established in accordance with Attachment A, item #7.

2. **a.** In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid manual. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.b.

b. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" will include all Medicaid expenditures on behalf of Demonstration Population 1 participants as defined in the demonstration approval letter.

c. At such time the State determines that it does not have sufficient title XXI funds to cover expenditures for Demonstration Population 1 and begins claiming title XIX funds for this population, the State will complete for each demonstration year a Form CMS-64.9WAIVER and/or 64.9P WAIVER reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.b.).

d. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration.

e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State

made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

f. The procedures related to this reporting process, report contents, and frequency must be discussed by the State in the Operational Protocol

3. a. For the purpose of calculating the budget neutrality expenditure cap referenced in Attachment A.7, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the demonstration eligibles as defined below. These will include only member months for Demonstration Population 1 whose expenditures are matched at the regular FMAP rate. This information should be provided to CMS in conjunction with the quarterly progress report referred to in subsection E of Section III. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol.

b. The term, "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

c. There will be one Medicaid eligibility group (MEG) under the demonstration. The MEG will be the parents of Medicaid and SCHIP children with incomes through 133 percent FPL (Demonstration Population 1). These are individuals who would be eligible for Medicaid under Section 1931 in the State Plan.

4. The standard Medicaid funding process will be used during the demonstration. New Jersey must continue to estimate total matchable Medicaid expenditures for the entire program on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable/Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2 c. of this Attachment. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 annually with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

5. CMS will provide Federal Financial Participation (FFP) at the applicable Federal matching rate for the following, subject to the limits referenced in Attachment A.7:

   a. Administrative costs, including those associated with the administration of the demonstration.
   b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.
   c. Net medical assistance expenditures made under Section 1115 demonstration authority, including those made in conjunction with the demonstration.

6. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

ATTACHMENT C

MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

The following describes the method by which budget neutrality will be assured under the demonstration. The demonstration will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the waiver period. This limit will be determined using a per capita cost method. In this way, the State will be at risk for the per capita cost (as determined by the method described below) for Demonstration Population 1, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of Demonstration Population 1, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for the entire demonstration period. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during the 5-year period for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year. Should the operational period for the demonstration be extended beyond the initial 5-year period, budget neutrality savings cannot be carried over for more than a 5-year period, regardless of the duration of extensions.

Amendments to HIFA budget neutrality agreements will only be considered in light of all currently approved HIFA demonstrations rather then than a demonstration-by-demonstration basis.

Base Year Expenditures

The base year expenditure and per capita amounts, and demonstration years trended per capita amounts must be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments; if necessary adjustments must be made. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act.

The base year will be State fiscal year 2003. Base year per capita costs for the Medicaid eligibility group (MEG), which are parents of Medicaid and SCHIP children who would be eligible for Medicaid under Section1931 in the State Plan, is as follows:

Demonstration Population 1:

Gender	Age Group	Income Criteria	SFY 2003 Per Capita Costs
Females	<45	<133%FPL	158.84
Males	<45	<133%FPL	124.53
Males and Females	45+	<133%FPL	269.25

Base year expenditures and trended per capita amounts will not be included for Medicaid State Plan amendments submitted after the established base year. All State Plan amendments submitted before or during the base year must be reflected in the base year data finalized with CMS.

Nothing in this approval is intended to limit the ways in which budget neutrality will be calculated if this demonstration is extended for subsequent periods.

Projecting Service Expenditures

Each demonstration year estimate of Medicaid service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in Attachment A number 3.a. Demonstration Years which do not align with State Fiscal Years or which fall beyond the range of years shown must be calculated by pro-rating the agreed-upon annual trend rate for the appropriate number of months.

The trend rate for each Medicaid Eligibility Group (MEG) for each year of the demonstration are listed below.

Demonstration Year	Trend Rates for all MEG
Beginning 09/1/2002	6.4%
Beginning 09/1/2003	6.4%
Beginning 09/1/2004	6.4%
Beginning 09/1/2005	6.4%
Beginning 09/1/2006	6.4%

How the limit will be applied
The limit calculated above from the trended service expenditures plus the DSH component will apply to actual expenditures for HIFA services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on

the time period through the termination date. If there are savings under the cap, they cannot be carried over for more than a 5-year period, regardless of the timing of extensions.

Expenditure Review
CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

ATTACHMENT D

OPERATIONAL PROTOCOL

The State will be responsible for developing a detailed protocol describing this demonstration. The protocol will serve as a stand-alone document that reflects the operating policies and administrative guidelines in the demonstration. The revision to the protocol will be submitted to CMS for approval within 30 days of demonstration's amendment approval date. During the demonstration, subsequent changes to the protocol which are the result of major changes in policy or operation procedures should be submitted no later than 90 days prior to the date of implementation of the change(s) for approval by CMS. The State shall assure and monitor compliance with the protocol. The protocol will include descriptions of the following:

1. The administration that will be in place to implement, monitor, and run the demonstration, and the tasks that each entity will perform.

2. How administration of the demonstration will be coordinated with the SCHIP and Medicaid programs.

3. The benefit package provided to the demonstration populations.

4. The delivery system for the demonstration populations, including enrollment practices that facilitate access to the system for family members.

5. The premium assistance program, including the requirements for participation, the process for determining whether the benefit package meets benchmark, the provision of wrap-around services, and policies that ensure that cost sharing limits are not exceeded.

6. The process for determining whether the delivery system is adequate to support the addition of the demonstration populations and a plan for monitoring the system to ensure that it remains adequate.

7. The cost sharing requirements and procedures for ensuring that cost sharing does not exceed the 5 percent limit.

8. The strategy for monitoring or preventing substitution of coverage under group health plans for the demonstration populations.

9. The process for ensuring that care is not interrupted for the approved State plan population or the demonstration populations should the State expend the full amount of the available Federal funds during the demonstration period.

10. The procedures for meeting the financial requirements as specified in Attachments A and Attachment B.

11. The Operational Protocol must include the State's monitoring plan to track changes in the uninsured rate and trends in sources of insurance, including submission of progress reports discussed in Section III. Include in the description of the plan information on the sources of data and adjustments that were made to establish the base line and which will need to be made in the future. The State should plan on monitoring whether there are unintended consequences of the demonstration such as high levels of substitution of private coverage and major decreases in employer contribution levels. This section should discuss the State's plans to measure and report on the following: changes in the uninsured rate for the population groups listed above; changes in the insured rates for the insurance coverage categories and population groups listed above; the degree of substitution of public coverage for employer coverage; the lengths of time enrollees have been uninsured prior to enrolling in the demonstration; the extent to which employers reduce their contributions for employer sponsored insurance; the extent to which employers discontinue employer sponsored insurance for their employees, and the extent to which individuals appear to be dropping employer coverage in order to enroll in the demonstration.